U.S. Senate
Republican Policy
Committee

Legislative Notice

Jon Kyl, Chairman

No. 28 July 7, 2003

S. 11 – The Patients First Act of 2003

Calendar No. 186

Placed on the Senate Calendar on June 27, 2003, under Rule 14. No written report was issued.

NOTEWORTHY

- On Monday, July 7, the Majority Leader or his designee will move to consider S. 11, the Patients First Act of 2003. The bill protects patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

- It is expected that a cloture petition will be filed today, and that a cloture vote on or in relation to S. 11 will occur on Wednesday, July 9.

- S. 11 was introduced on June 27 by Senator Ensign and 10 cosponsors: Senators Frist, McConnell, Kyl, Thomas, Inhofe, Hagel, Enzi, Voinovich, Bunning, and Cornyn. It is similar to H.R. 5, the "Help Efficient, Accessible, Low-Cost, Timely Healthcare (HEALTH)" Act of 2003, which passed the House of Representatives by a vote of 229 to 196 on March 13.

- There is no official score from the Congressional Budget Office (CBO) on S. 11. However, on March 10, CBO announced that H.R. 5 "would reduce federal direct spending by $14.9 billion over the FY 2004 - 2013 period for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits Program (FEHBP), and other federal health benefits programs." The Joint Economic Committee estimates that the Federal government would save an additional $16.7 billion over 10 years due to reduced costs associated with defensive medicine.

- As of press time, there is no Statement of Administration Policy (SAP) for S. 11, but one in support of the bill is expected shortly. On March 13, the White House issued a SAP strongly supporting H.R. 5 and urging swift passage of medical liability reform in order to improve access to health care providers and reduce excessive health care costs.

HIGHLIGHTS

- **Sets sensible limits on non-economic damages to help restrain medical liability premium increases while ensuring unlimited economic compensation for patients injured by negligence.** The bill provides an unlimited amount of damages for actual economic losses. In addition, the measure allows up to $250,000 to be rewarded for non-economic damages (commonly referred to as "pain and suffering" damages).

- **Reserves punitive damages for cases that justify them.** S. 11 permits the award of punitive damages if it is proven by clear and convincing evidence that the defendant acted with malicious intent to injure the claimant, or that the defendant deliberately failed to avoid unnecessary injury to the victim. The legislation allows punitive damages up to the greater of $250,000 or twice economic damages.

- **Allows providers to make judgment payments over time rather than in one lump sum.** The legislation authorizes periodic payments of future damages to claimants for awards equaling or exceeding $50,000.

- **Assures claims are filed within a reasonable time period.** S. 11 requires that a lawsuit be brought within three years of the date of injury or one year after the claimant discovers or should have discovered the injury, whichever occurs first. Establishes exceptions for cases involving minors.

- **Informs juries when additional payments for injuries have occurred (also referred to as the collateral source rule).** Juries could be informed that a victim has received additional payment from other sources, such as a health insurer.

- **Scope.** Preempts state law except in those cases where states have enacted stronger medical liability reforms or have enacted their own damage limits. S. 11 does not preempt state law with respect to compensatory or punitive damages, regardless of the limit. The measure also supercedes the Federal Tort Claims Act with respect to damage awards, fee caps, statute of limitations, and collateral source payments.

BACKGROUND

For years health care providers have faced difficulty obtaining affordable medical liability coverage. The problem is now so great that patients are being deprived access to crucial medical care as hospitals and physicians find it increasingly difficult to continue offering certain services. Premium

increases have jumped as much as 81 percent over the last two years, according to some insurers.[1] These cost increases are attributed to an overly expensive litigation system – a system that is slow, unpredictable, largely random and standardless.[2]

Liability premium rates are highest for neurosurgery, cardiovascular surgery, and obstetrics and gynecology (ob/gyn). However, many other medical disciplines, such as internal medicine and general surgery, also are reporting significant premium increases. Hospitals, physicians, nurse practitioners and other providers of care have been calling for liability reform to help reduce these increased costs so they may continue offering vital medical care for patients and their families.

According to the American Medical Association, 19 states now face a medical liability crisis, 25 states show problem signs, and 6 states report "okay" status.[3] While the crisis is reminiscent of the 1970s, the difference today is the increase in large jury awards. According to the Physician Insurance Association of America (PIAA), it is the amount paid per claim and its unpredictable size that brings new challenges for the liability insurance system. Recent PIAA data show a four-fold increase in the percentage of jury awards in excess of $1 million between 1991 and 2002. Data also show an increase in the average malpractice indemnity payment (awarded by jurors or settled out of court). The average indemnity payment in 2001 was more than $310,000 – a 60-percent increase in the last five years.[4]

Moreover, the medical liability insurance industry is experiencing an increase in the cost of medical liability claims. For instance, every premium dollar collected in 2001 resulted in $1.53 in losses (which are the dollars set aside to pay judgments and settlements for claims filed). Ten years earlier, for every premium dollar collected, the loss was $1.03 – a clear sign that claims payments for judgments and settlements are rising faster than incoming premium payments.[5]

A recent report released by Tillinghast-Towers Perrin, an actuarial firm, found similar liability-related losses, leading to a 15-percent reduction of medical underwriting capacity from the marketplace over the past three years.[6] Those insurers that left the medical underwriting market include St. Paul Companies (formerly the largest medical liability carrier in the United States), PHICO, Frontier Insurance Group, Doctors Insurance Reciprocal, and MIXX (except for policies issued in New Jersey). As a result, patients are finding it increasingly difficult to obtain affordable, quality health care, and those who can afford it are paying more in the form of costlier health insurance.

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[1]Hospitals and Health Networks, April 2002.

[2]"Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System," U.S. Department of Health and Human Services, July 24, 2002.

[3]"State Crisis Map," American Medical Association, July 7, 2003.

[4]PIAA Data Sharing Project, May 2002.

[5]"Medical Malpractice, Combined Ratio," AM Best.

[6]"A New Crisis for the Med Mal Market?" Tillinghast-Towers Perrin, February 11, 2003.

Given the impact on patient access to medical care, Congress has considered medical liability legislation on several occasions. The issue was debated extensively in the 104th Congress and almost every session thereafter. Most recently, in July 2002, the Senate debated a second-degree amendment sponsored by Senator McConnell to S. 812, The Greater Access to Affordable Pharmaceuticals Act. The amendment was tabled by a vote of 57-42, but it was another attempt to prevent abusive medical litigation through a uniform statute of limitations, strict evidentiary standards, more reasonable punitive damages awards, and different treatment of collateral source payments.

BILL PROVISIONS

S. 11 was introduced on June 27, 2003, by Senators Ensign, Frist, McConnell, Kyl, Thomas, Inhofe, Hagel, Enzi, Voinovich, Bunning, and Cornyn. The measure was placed on the Senate Calendar under Rule 14.

Section 1, Title.

This Act may be cited as the "Patients First Act of 2003."

Section 2, Findings and Purpose.

The measure establishes a series of findings. First, the bill finds that the current civil justice system adversely affects patient access to quality health care services since claims are not resolved in a timely manner. Moreover, the liability system deters health care professionals from sharing information which ultimately impedes efforts to improve patient safety. Second, the measure finds that the health care and insurance industries affect interstate commerce by contributing to the high costs of health and premiums for health care liability insurance purchased by health care providers. Third, the bill finds that the health care liability system has a significant effect on the amount, distribution, and use of Federal funds due to the large number of individuals receiving health care benefits administered by the Federal Government, as well as the large amount of Federal tax receipts excluded because employers and individuals must pay higher health insurance premiums.

Section 2 also specifies the purpose of the bill. It is specifically designed to improve the availability of health care services, reduce the incidence of "defensive medicine" and lower the cost of health care liability insurance, ensure that persons with meritorious health care injury claims receive fair and adequate compensation, improve the fairness and cost-effectiveness of medical liability awards, and enhance the sharing of critical health care information as a way to avoid unintended injury and improve patient care.

Section 3, Encouraging Speedy Resolution of Claims.

Requires that a lawsuit be brought within three years of the date of injury or one year after the claimant discovers or should have discovered the injury, whichever occurs first. Allows for exceptions upon proof of fraud, intentional concealment, or the presence of a foreign body which has no therapeutic or diagnostic purpose in the injured person. Section 3 liberalizes the statute of limitations for children under the age of 6.

Section 4, Compensating Patient Injury.

Permits patients to fully recover their economic damages, such as hospital bills and lost wages, without any limitation. Patients also can be awarded up to $250,000 for any non-economic damages, regardless of the number of parties against whom the action is brought or the number of separate claims or actions brought with respect to the same occurrence. The section also creates a "fair share rule," ensuring that each party is responsible for their own share of damages and not for the share of any other defendant.

Section 5, Maximizing Patient Recovery.

Requires court supervision of payment arrangements to protect against conflicts of interest that may result in fewer damages actually paid to the claimant. Also establishes attorney contingency fees using the following scale: 1) 40 percent of the first $50,000 recovered by the claimant; 2) 33.3 percent of the next $50,000; 3) 25 percent of the next $500,000; and 4) 15 percent of any amount recovered in excess of $600,000. In addition, the section creates an expert witness rule, requiring individuals to be health care professionals who are appropriately credentialed or licensed, have experience in treating the diagnosis under review, and are substantially familiar with the standards of care related to the lawsuit.

Section 6, Additional Health Benefits.

Juries could be informed that a victim has received additional payment (also referred to as collateral source payments) from other sources, such as a health insurer. Payors of collateral source benefits would not be allowed to recover such payments regardless of any judgment or settlement of the lawsuit.

Section 7, Punitive Damages.

Permits punitive damages, if otherwise permitted by applicable State or Federal law, only if it is proven by clear and convincing evidence that the defendant acted with malicious intent to injure the claimant, or that the defendant failed to avoid unnecessary injury to the victim.

Specifies certain factors to be considered when determining punitive damages, including severity, duration or concealment, profitability, number of products sold or medical procedures rendered for compensation, criminal penalties, and any civil fines assessed as a result of the defendant's conduct. The amount of punitive damages shall be the greater of two times economic damages or $250,000. The section also prohibits the award of punitive damages for medical products unless the

claimant demonstrates by clear and convincing evidence that the manufacturer or distributor failed to comply with specific requirements imposed by the Federal Food, Drug and Cosmetic Act. In addition, the section prohibits liability from being assessed against a physician in a product liability lawsuit merely because the doctor prescribed a drug that was approved by the Food and Drug Administration.

Section 8, Authorization of Payment of Future Damages to Claimants in Health Care Lawsuits.

Allows court judgments, at the request of any party, to pay future damages periodically. Such authorization applies only to future awards equaling or exceeding $50,000.

Section 9, Definitions.

Establishes a series of definitions ranging from the term "claimant" to "health care lawsuit."

Section 10, Effect on Other Laws.

Excludes suits for vaccine-related death or injury from the requirements of S. 11 if otherwise covered under the National Vaccine Injury Compensation Program.

Section 11. State Flexibility and Protection of States' Rights.

Preempts state law except in those cases where states have enacted stronger medical liability reforms or have enacted their own damage limits. S. 11 does not preempt state law with respect to compensatory or punitive damages, regardless of the limit. The measure also supercedes the Federal Tort Claims Act with respect to damage awards, fee caps, statute of limitations, and collateral source payments.

Section 12, Applicability; Effective Date.

Specifies that S. 11 shall apply to any health-care lawsuit brought in a Federal or State court, or subject to an alternative dispute resolution system, that is initiated on or after the date of enactment. Any health-care lawsuit arising from an injury occurring prior to the date of enactment shall be governed by the applicable statute of limitations in effect at the time of injury.

Section 13, Sense of Congress.

Expresses the sense of Congress that a health insurer should be liable for damages for harm caused when it makes a decision as to what care is medically necessary and appropriate.

ADMINISTRATION POSITION

As of press time, there is no Statement of Administration Policy (SAP) for S. 11. However, on March 13, the White House issued a SAP strongly supporting H.R. 5 and urging swift passage of medical liability reform in order to improve access to health care providers and reduce excessive health care costs.

COST

There is no official score from the Congressional Budget Office (CBO) on S. 11. However, on March 10, CBO announced that H.R. 5, a similar bill, "would reduce federal direct spending by $14.9 billion over the FY 2004 - 2013 period for Medicare, Medicaid, the government's share of premiums for annuitants under the Federal Employees Health Benefits Program (FEHBP), and other federal health benefits programs." Further, CBO estimates the bill would increase federal revenues by $3 billion over the same period. [For details, see CBO's report on H.R. 5, available from www.cbo.gov.] The Joint Economic Committee estimates that the Federal government would save an additional $16.7 billion over 10 years due to reduced costs associated with defensive medicine.

POSSIBLE AMENDMENTS

No amendments were known at press time. If cloture is obtained, amendments are likely but have to be germane.

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